		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044784

Facility Name: St Benedict Nursing & Rehab

Address: 6930 W. Touhy (Number) Niles (City) 60714 (Zip Code)

County: Cook

Telephone Number: 847 647-0003 **Fax #** 847-647-1936

IDPA ID Number: 23-7061646009

Date of Initial License for Current Owners: 3/1/00

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** 847-236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2000 to 6/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) Richard Sgarlata, C.P.A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd., Suite 300, Deerfield, IL 60015
(Telephone) 847-236-1111 Fax # 847-236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,613	14,977	2,004	21,594	8
9	SNF/PED					9
10	ICF	2,694	9,096		11,790	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,307	24,073	2,004	33,384	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.39%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 3/1/00

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 3/1/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 7 and days of care provided 2,004

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [x]

Tax Year: 12/31 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	383,365	35,688		419,053		419,053	(103,255)	315,798			1
2	Food Purchase		272,754		272,754		272,754	(69,476)	203,278			2
3	Housekeeping	160,260			160,260		160,260	(36,315)	123,945			3
4	Laundry	124,573	54,638		179,211		179,211	(40,609)	138,602			4
5	Heat and Other Utilities			155,278	155,278		155,278	(35,186)	120,092			5
6	Maintenance	121,364	12,771	104,198	238,333		238,333	(99,181)	139,152			6
7	Other (specify):*											7
8	**TOTAL General Services**	789,562	375,851	259,476	1,424,889		1,424,889	(384,022)	1,040,867			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,446,173	10,067	114,426	1,570,666		1,570,666	1,720	1,572,386			10
10a	Therapy	41,137	960		42,097		42,097		42,097			10a
11	Activities	98,174	12,880	2,939	113,993		113,993		113,993			11
12	Social Services	98,036	7,955	2,160	108,151		108,151		108,151			12
13	Nurse Aide Training											13
14	Program Transportation			317	317		317	(317)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,683,520	31,862	133,042	1,848,424		1,848,424	1,403	1,849,827			16
	C. General Administration											
17	Administrative	84,255		204,810	289,065		289,065	(204,810)	84,255			17
18	Directors Fees											18
19	Professional Services			13,092	13,092		13,092	115,187	128,279			19
20	Dues, Fees, Subscriptions & Promotions			17,929	17,929		17,929	(13,094)	4,835			20
21	Clerical & General Office Expenses	162,902	35,801	80,137	278,840		278,840	92,443	371,283			21
22	Employee Benefits & Payroll Taxes			766,204	766,204		766,204	35,905	802,109			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,864	3,864		3,864	(75)	3,789			24
25	Other Admin. Staff Transportation			1,868	1,868		1,868	(1,868)				25
26	Insurance-Prop.Liab.Malpractice			86,454	86,454		86,454		86,454			26
27	Other (specify):*											27
28	**TOTAL General Administration**	247,157	35,801	1,174,358	1,457,316		1,457,316	23,688	1,481,004			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,720,239	443,514	1,566,876	4,730,629		4,730,629	(358,931)	4,371,698			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Benedict Nursing & Rehab #0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			324,692	324,692		324,692	(54,101)	270,591			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			5,796	5,796		5,796	(5,796)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			209	209		209		209			35
36	Other (specify):*			12,228	12,228		12,228		12,228			36
37	**TOTAL Ownership**			342,925	342,925		342,925	(59,897)	283,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	46,087	85,645	45,247	176,979		176,979		176,979			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*	197,873	2,138	48,103	248,114		248,114	(248,114)				43
44	**TOTAL Special Cost Centers**	243,960	87,783	147,553	479,296		479,296	(248,114)	231,182			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,964,199	531,297	2,057,354	5,552,850		5,552,850	(666,942)	4,885,908			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (111,379)	43	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,990	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,503)	21		24
25	Fund Raising, Advertising and Promotional	(8,417)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,677)	20		28
29	Other-Attach Schedule	(601,231)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (779,217)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	112,275		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 112,275		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (666,942)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Benedict Nursing & Rehab

ID# 0044784

Report Period Beginning: 7/1/2000

Ending: 6/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous income	$ (2,642)	21	1
2	Billboard rental	(1,100)	21	2
3	Assisted living	(136,735)	43	3
4	Non-Care depreciation	(63,607)	30	4
5	Non-Care real estate taxes	(5,796)	33	5
6	Other revenue-Cafeteria	(2,269)	2	6
7	Other revenue-Telephone	(1,197)	21	7
8	Personal Care	(175)	10	8
9	Capitalized R&M	(7,407)	6	9
10	Out of c/r period seminar expense	(75)	24	10
11	Transportation income	(317)	14	11
12	Transportation income	(1,868)	25	12
13	Transportation income	(2,185)	21	13
14	House rental income	(39,280)	6	14
15				15
16	INDEPENDENT LIVING EXPENSES:			16
17	Dietary	(103,255)	1	17
18	Food	(67,207)	2	18
19	Housekeeping	(36,315)	3	19
20	Laundry	(40,609)	4	20
21	Utilities	(35,186)	5	21
22	Maintenance	(54,006)	6	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(601,231)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(103,255)	0	0	0	0	0	0	0	0	0	0	(103,255)	1
2	Food Purchase	(69,476)	0	0	0	0	0	0	0	0	0	0	(69,476)	2
3	Housekeeping	(36,315)	0	0	0	0	0	0	0	0	0	0	(36,315)	3
4	Laundry	(40,609)	0	0	0	0	0	0	0	0	0	0	(40,609)	4
5	Heat and Other Utilities	(35,186)	0	0	0	0	0	0	0	0	0	0	(35,186)	5
6	Maintenance	(100,693)	1,512	0	0	0	0	0	0	0	0	0	(99,181)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(385,534)	1,512	0	0	0	0	0	0	0	0	0	(384,022)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(175)	1,895	0	0	0	0	0	0	0	0	0	1,720	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(317)	0	0	0	0	0	0	0	0	0	0	(317)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(492)	1,895	0	0	0	0	0	0	0	0	0	1,403	16
	C. General Administration													
17	Administrative	0	(204,810)	0	0	0	0	0	0	0	0	0	(204,810)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	115,187	0	0	0	0	0	0	0	0	0	115,187	19
20	Fees, Subscriptions & Promotions	(13,094)	0	0	0	0	0	0	0	0	0	0	(13,094)	20
21	Clerical & General Office Expenses	(62,627)	155,070	0	0	0	0	0	0	0	0	0	92,443	21
22	Employee Benefits & Payroll Taxes	0	35,905	0	0	0	0	0	0	0	0	0	35,905	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(75)	0	0	0	0	0	0	0	0	0	0	(75)	24
25	Other Admin. Staff Transportation	(1,868)	0	0	0	0	0	0	0	0	0	0	(1,868)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(77,664)	101,352	0	0	0	0	0	0	0	0	0	23,688	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(463,690)	104,759	0	0	0	0	0	0	0	0	0	(358,931)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 **Report Period Beginning:** 7/1/2000 **Ending:** 6/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(61,617)	7,516	0	0	0	0	0	0	0	0	0	(54,101)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(5,796)	0	0	0	0	0	0	0	0	0	0	(5,796)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(67,413)	7,516	0	0	0	0	0	0	0	0	0	(59,897)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(248,114)	0	0	0	0	0	0	0	0	0	0	(248,114)	43
44	**TOTAL Special Cost Centers**	(248,114)	0	0	0	0	0	0	0	0	0	0	(248,114)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(779,217)	112,275	0	0	0	0	0	0	0	0	0	(666,942)	45

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Salary	$	Resurrection Health Care	100.00%	$ 126,274	$ 126,274	1
2	V	22	Employee benefits		Resurrection Health Care	100.00%	35,905	35,905	2
3	V	19	Data processing		Resurrection Health Care	100.00%	98,404	98,404	3
4	V	19	Purchasing		Resurrection Health Care	100.00%	16,783	16,783	4
5	V	6	Operation of plant		Resurrection Health Care	100.00%	1,512	1,512	5
6	V	10	Nursing administration		Resurrection Health Care	100.00%	1,895	1,895	6
7	V	21	Miscellaneous A&G		Resurrection Health Care	100.00%	28,796	28,796	7
8	V	30	Capital		Resurrection Health Care	100.00%	7,516	7,516	8
9	V								9
10	V	17	Intercompany services	204,810				(204,810)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 204,810			$ 317,085	$ * 112,275	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Salary				$	$		$ 126,274	1
2	22	Employee benefits							35,905	2
3	19	Data processing							98,404	3
4	19	Purchasing							16,783	4
5	6	Operation of plant							1,512	5
6	10	Nursing adminstratioin							1,895	6
7	21	Miscellaneous A&G							28,796	7
8	30	Capital							7,516	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 317,085	25

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Benedict Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044784

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,961 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living

Day Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2000	$ 2,585,200	1
2	Land study		2000	4,620	2
3	TOTALS			$ 2,589,820	3

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2000	1991	$ 4,247,413	$ 123,698	35	$ 119,607	$ (4,091)	$ 179,466	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet 1st & 2nd floor halls, dining rooms, patient rooms (60293)			2000	48,482		20	2,424	2,424	2,424	9
10	Facility Sign (9757)			2000	7,845		20	392	392	392	10
11	Grease Basin (21160)			2000	17,015		20	850	850	850	11
12	Alternator Switcheds (785)			2001	631		20	32	32	32	12
13	Lawn Sprinkler System (940)			2001	756		20	38	38	38	13
14	High Velocity Water Jet (400)			2000	322		20	16	16	16	14
15	Catch Basin (1280)			2000	1,029		20	51	51	51	15
16	Sewer Ejector Pump Repairs (3972)			2001	3,194		20	160	160	160	16
17	Sewer Ejector Pump Repairs (3179			2001	2,556		20	128	128	128	17
18											18
19											19
20											20
21	Allocation from Resurrection Healthcare					7,516		7,516			21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replacement of hot water system (14725)	2001	$ 11,840	$	20	$ 592	$ 592	$ 592	37
38	Replacement of hot water system (14725)	2001	11,840		20	592	592	592	38
39	Asbestos removal from boiler (12630)	2001	10,156		20	508	508	508	39
40	HVAC (1894)	2001	1,523		20	76	76	76	40
41	Carpet (1000)	2001	804		20	40	40	40	41
42	Fire alarm (526)	2001	423		20	21	21	21	42
43	HVAC (1735)	2001	1,395		20	70	70	70	43
44	Fire alarm (2252)	2001	1,811		20	91	91	91	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,369,035	$ 131,214		$ 133,204	$ 1,990	$ 185,547	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 628,975	$ 137,387	$ 137,387	$		$ 199,063	71
72	Current Year Purchases	10,732						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 639,707	$ 137,387	$ 137,387	$		$ 199,063	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,598,562	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 268,601	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 270,591	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,990	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 384,610	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted Living	$ 1,220,262	$ 63,607	$ 93,701	86
87	Misc. building improvement	590			87
88					88
89					89
90					90
91	TOTALS	$ 1,220,852	$ 63,607	$ 93,701	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 209 Description: Copier $209
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 31,746	$		$ 31,746	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,501			13,501	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	1866 hrs	46,087				1,866	46,087	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				44,238		44,238	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						41,408		41,408	13
14	TOTAL			$ 46,087		$ 45,247	$ 85,646	1,866	$ 176,980	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Benedict Nursing & Rehab **#** 0044784 **Report Period Beginning:** 7/1/2000 **Ending:** 6/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 797	$	1
2	Cash-Patient Deposits	10,796		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	407,343		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,360		7
8	Accounts Receivable (owners or related parties)	988,332		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,412,628	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,589,820		13
14	Buildings, at Historical Cost	5,359,396		14
15	Leasehold Improvements, at Historical Cost	24,565		15
16	Equipment, at Historical Cost	784,824		16
17	Accumulated Depreciation (book methods)	(431,181)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	61,140		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,388,564	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,801,192	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 110,083	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	334,990		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 445,073	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 445,073	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,356,119	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,801,192	$	48

***(See instructions.)**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,691,401	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,691,401	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	664,718	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 664,718	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,356,119	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,122,243	1
2	Discounts and Allowances for all Levels	(637,773)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,484,470	3
	B. Ancillary Revenue		
4	Day Care	93,358	4
5	Other Care for Outpatients		5
6	Therapy	211,065	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 304,423	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,935	13
14	Non-Patient Meals	2,269	14
15	Telephone, Television and Radio	1,197	15
16	Rental of Facility Space	174,295	16
17	Sale of Drugs	32,026	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,536	19
20	Radiology and X-Ray		20
21	Other Medical Services	109,165	21
22	Laundry	16,006	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 348,429	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	58,512	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58,512	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	21,734	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,734	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,217,568	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,424,889	31
32	Health Care	1,848,424	32
33	General Administration	1,457,316	33
	B. Capital Expense		
34	Ownership	342,925	34
	C. Ancillary Expense		
35	Special Cost Centers	425,093	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,552,850	40
41	**Income before Income Taxes (line 30 minus line 40)****	664,718	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 664,718	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,988	2,240	$ 62,452	$ 27.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,363	14,304	313,841	21.94	3
4	Licensed Practical Nurses	12,321	14,345	254,538	17.74	4
5	Nurse Aides & Orderlies	61,460	73,083	776,992	10.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,866	2,058	46,087	22.39	7
8	Rehab/Therapy Aides	3,665	3,868	41,136	10.63	8
9	Activity Director	1,039	1,287	24,167	18.78	9
10	Activity Assistants	8,474	9,124	74,007	8.11	10
11	Social Service Workers	6,466	6,999	98,036	14.01	11
12	Dietician	864	871	23,458	26.93	12
13	Food Service Supervisor	2,008	2,304	47,236	20.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,065	33,366	312,671	9.37	15
16	Dishwashers					16
17	Maintenance Workers	6,195	6,794	121,364	17.86	17
18	Housekeepers	17,392	19,740	160,260	8.12	18
19	Laundry	13,242	15,337	124,573	8.12	19
20	Administrator	1,972	2,320	84,255	36.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,172	13,297	162,902	12.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,036	2,332	38,351	16.45	31
32	Other Health Care(specify)					32
33	Other(specify)	17,370	19,962	197,873	9.91	33
34	TOTAL (lines 1 - 33)	211,958	243,631	$ 2,964,199 *	$ 12.17	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	13,200	9-3	36
37	Medical Records Consultant	Monthly	672	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,939	11-3	44
45	Social Service Consultant	62	2,160	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	62	$ 18,971		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,283	$ 61,576	10-3	50
51	Licensed Practical Nurses	1,656	52,178	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,939	$ 113,754		53

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peter Goschy	Administrator	0	$ 84,255
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,255

B. Administrative - Other

Description	Amount
Resurrection Intercompany Services	$ 204,810
TOTAL (agree to Schedule V, line 17, col. 3)	$ 204,810
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R Consulting	Accounting	$ 6,115
Toshiba	Computer consultant	363
Achieve Software	Software consultant	110
Bell Boyd & Company	Legal services	6,504
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 13,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,812
Unemployment Compensation Insurance	6,420
FICA Taxes	204,740
Employee Health Insurance	469,769
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement plan	24,300
Employee Assistance Program	2,813
Pre-employment medical	200
Misc. employee benefits	8,954
Allocation from Resurrection Health Care	35,905
Tuition reimbursement	4,196
TOTAL (agree to Schedule V, line 22, col.8)	$ 802,109

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & subscriptions	4,835
Advertising & promotion	8,417
Yellow pages	4,677
Less: Public Relations Expense	( )
Non-allowable advertising	(8,417)
Yellow page advertising	(4,677)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,835

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,789
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,789

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN $1,818**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,195** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available at this time**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.